UNITED STATES MEDICAL LICENSING EXAMINATION™ (USMLE™)
2006 STEP 3 APPLICATION

For applications submitted to FSMB by September 1, 2006

Refer to the Application Instructions when completing this form. Complete all three pages. Type or print in uppercase block letters. Use black ink only.

1. LICENSING AUTHORITY
See Instructions for Board Code.

Board Code _____ Name of Licensing Authority whose requirements you are using to apply for Step 3. _____

2. FEE ENCLOSED
See State Specific Instruction Sheet for fee.

$_____ **U.S. DOLLARS (non-refundable fee)**

3. NAME
Print your name exactly as it appears on the unexpired, government-issued identification you plan to present at the test center. See Instructions, "Completing Your Application."

LAST (Surname) and Suffix

FIRST and Middle Name(s)

If you have applied previously under another name for any examination listed in Item 11 below, please provide that name and a copy of the legal document which verifies this change.

Last _____ First _____ Middle _____

4. DATE OF BIRTH
Indicate month as shown: Jan-01; Feb-02; Mar-03; Apr-04; May-05; Jun-06; Jul-07; Aug-08; Sep-09; Oct-10; Nov-11; Dec-12

MONTH _____ DAY _____ YEAR 19__

5. U.S. SOCIAL SECURITY AND NATIONAL IDENTIFICATION NUMBERS
Enter your S.S.Number and/or the official number assigned by your country if outside the U.S. **See Instructions for Country Code.**

U.S. Social Security Number _____

National Identification Number _____

Country Code _____ Issuing Country _____

6. GENDER

☐ Male ☐ Female

7. CITIZENSHIP UPON ENTERING MEDICAL SCHOOL
See Instructions for Country Code.

Country Code _____ Name of Country _____

8. MEDICAL EDUCATION
See Instructions for Country Code.

Graduation Date– Indicate month as shown: Jan-01; Feb-02; Mar-03; Apr-04; May-05; Jun-06; Jul-07; Aug-08; Sep-09; Oct-10; Nov-11; Dec-12

Medical School of Graduation _____

Country Code _____ Country of Medical School _____ Graduation Date MONTH _____ YEAR _____

Degree: ☐ M.D. ☐ D.O. ☐ Other (specify): _____

If school is outside the U.S. or Canada: ECFMG Certified: ☐ Yes ☐ No If yes, date issued: ____/____/_____ MO DY YR

5th Pathway Program: ☐ Yes ☐ No If yes, date completed: ____/____/_____ MO DY YR

FOR OFFICE USE ONLY			SCC	Y	N
DEGREE	Y	N	5th PATHWAY	Y	N
ECFMG	Y	N	EXAM PREREQUISITES	Y	N

9. POSTGRADUATE MEDICAL EDUCATION
Check one box only.

☐ I have not participated in a graduate medical education program.

☐ I will begin a graduate medical education program on ____/_____. MO YR

☐ I am currently serving in my first year graduate medical education program which began on ____/_____. MO YR

☐ I have completed satisfactorily _____ year(s) in a graduate medical education program from ____/_____ MO YR to ____/_____. MO YR

Most recent program and hospital:

See Instructions for Program Code.

Program Code _____ Program Name _____

Hospital Name _____

City _____

Program Director's Name _____ E-mail _____ Phone _____

NAME _____

10. SPECIALTY
See Instructions for Specialty Code.

Specialty Code ____ Name of Specialty or Planned Specialty _____

11. USMLE IDENTIFICATION NUMBER

Identification Number (If Known)

USMLE ☐ – ☐☐☐ – ☐☐☐☐ – ☐

12. USMLE PASSED
Record the administration date of each examination passed and the number of attempts.
Date Passed –
Indicate month as shown:
Jan-01; Feb-02; Mar-03; Apr-04; May-05; Jun-06; Jul-07; Aug-08; Sep-09; Oct-10; Nov-11; Dec-12

Examination	Date Passed (MONTH ☐☐ YEAR ☐☐☐☐)	# of Attempts
USMLE Step 1	☐☐ ☐☐☐☐	☐☐
USMLE Step 2CK	☐☐ ☐☐☐☐	☐☐
USMLE Step 2 CS	☐☐ ☐☐☐☐	☐☐

13. ADDRESS
This address will be used for correspondence regarding registration for Step 3. Print your current mailing address.

If you provide an address outside the U.S., correspondence relating to Step 3 may be significantly delayed. Provide a U.S. address, if possible.

If your address changes or is different for score reporting, see Instructions, "Change of Address."

See Instructions for Country Code.

*an e-mail address must be provided to complete the application.

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

City _____ State/Province ☐☐

Country _____ Country Code ☐☐☐

ZIP/Postal Code ☐☐☐☐☐ – ☐☐☐☐ Daytime Telephone Number ☐☐☐☐☐☐☐☐☐☐

E-mail Address _____

14. TEST ACCOMMODATIONS
Check this box if you are requesting test accommodations.

☐ I have a documented disability covered under the American with Disabilities Act and am requesting test accommodations. **(Checking this box does not constitute an official request. You must submit your request for test accommodations and accompanying documentation at the same time as this application. See Instructions, "Applying for Test Accommodations.")**

15. DATA RELEASE
Release of Step 3 Data

☐ The NBME reports USMLE total scores to LCME- and AOA-accredited medical schools for their students and graduates. This data is used by the schools to monitor the outcome of their educational process and as part of ongoing quality improvement activities. Only a total score is provided. If you do not wish to have your Step 3 score reported to your medical school of graduation, please check the box provided to the left.

Provision of the following information is voluntary. The information will be used for research purposes only. You are encouraged to provide the information. The processing of your application will not be affected by your choice in this regard.

Select the 1 option which best describes your racial/ethnic

1 ☐ American Indian/ Alaskan Native
2 ☐ Asian
3 ☐ Native Hawaiin or other Pacific Islander
4 ☐ Hispanic or Latino
5 ☐ Black or African American
6 ☐ White
7 ☐ Other

Is English your native language?

☐ Yes ☐ No

UNITED STATES MEDICAL LICENSING EXAMINATION™

2006 STEP 3 APPLICATION

CERTIFICATION OF IDENTITY

This form must be signed by a notary public/commissioner of oaths. When completed and submitted to the Federation, this form becomes part of your USMLE record and will be used to identify you when you interact with the Federation if you need to re-apply for the Step 3.

This Certification of Identity is valid for this and any subsequent Step 3 application(s) submitted to the Federation within a period of five years from the date of the applicant's signature. If you do not sit for this administration of Step 3 or must retake Step 3, it is not necessary to submit another Certification of Identity as long as this form is on file with the Federation of State Medical Boards and has not expired.

Web Req. ID: ☐☐☐☐☐☐☐☐☐☐

(If applicable for online applications)

☐☐☐-☐☐☐☐-☐☐☐☐-☐☐

USMLE IDENTIFICATION NO.

Type or print in uppercase block letters. Use black ink only.

ATTACH PHOTO HERE

Securely tape or glue in this squarea current front-view 2" x 2" photo. **(Print full name on back of photo before attaching.)**

Name:

Last First Middle

S.S./N.I. Number_____ Date of Birth ___ /___ /___ Gender Male ☐ Female ☐

Month Day Year

Licensing Authority for which Step 3 is being taken:_____

I certify that I am the individual named above, am represented in the attached photograph and that the signature below is my signature. I certify that I meet the eligibility requirements for Step 3 and that the information on this form is true and accurate. I also certify that I have read the most current version of the USMLE Bulletin of Information and all relevant instructions for this or any subsequent Step 3 application, that I am familiar with the contents of the Bulletin and agree to abide by the policies and procedures described therein. I authorize the release of my USMLE history to the medical licensing authority for which I am taking Step 3 and agree that my subsequent Step 3 score may also be released to the medical licensing authority.

Applicant's Signature _____

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

State of _____ County of_____

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this _____ day of _____, _____.

Notary Public Signature_____

Expiration Date* _____ / _____ / _____

Month Day Year

Notary stamp/seal here.

The notary's commision expiration date must be current and legible.